SECTION 5000

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5000 WAIVER PROGRAMS WITH NURSING CARE STATUS AND KATY BECKETT COVERAGE

5010 DEFINITIONS

Individuals can get Medicaid coverage if they meet the medical and financial requirements of one of the following coverage groups:

I. BME (Elderly) Waiver: For individuals who are 60 or older who need nursing care services and choose to remain at home. Some of the services are: care management, adult day care, personal care, home health, some transportation, emergency response system and mental health.

II. Waiver for Adults with Disabilities: For individuals who are age 18 up to and including age 59. This waiver provides the same services as the BME Waiver.

III. BMR (Bureau of Mental Retardation) Waiver: For individuals with mental retardation, there is no age limit. This waiver assists individuals with independent living arrangements.

IV. ALPHA (Alternative Living for Physically Handicapped Adults) Waiver: For individuals with a physical disability who are 18 or older. Individuals in this program manage and direct their own personal care attendant. Some of the services provided are case management, personal care, and an annual reassessment of needs.

These individuals are residing in the community and have been classified as needing nursing care services, however, rules of spousal impoverishment do not apply in determining their eligibility because they are not institutionalized.

When a husband and wife are living together and are both covered by a Waiver, they may allocate income to each other.

If a non-Waivered spouse applies for Medicaid, the income/assets of the waivered spouse are considered in accord with the rules for the applicant's coverable group. For example, for SSI-related coverage, the spouses are considered to be a couple.

A cost of care is determined for any month in which eligibility exists.

5020 DISABILITY DETERMINATION

Individuals applying for Waivers must have a coverable group.

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Persons receiving Social Security, Railroad Retirement, SSI based on disability or blindness, or Medicare automatically meet the disability/blind criteria in Section 3130/3120.

5030 CLASSIFICATION

Individuals must be in need of nursing care. This determination is done by the Department of Human Services or designated agency.

5040 ASSETS

The waivered individual's assets must not exceed the SSI-related asset limit for an individual. (see Section 3370)

Countable assets are defined in Section 3330 with the following exceptions:

I. Assets of a non-waivered spouse are not deemed to an individual eligible for waiver programs effective the 1st day of the month the individual is determined to be in nursing care status. Assets that are owned jointly are considered wholly owned by the individual.

II. If both eligible individuals are in a waiver status, the asset limit is $2000 for each.

III. There is no computation of the community spouse's protected share of assets.

5050 TRANSFER OF ASSETS

Other than a transfer between spouses, transfers by the individual or their spouse may be subject to a penalty. Follow the procedures outlined in Section 4120.

5060 INCOME

Income guidelines for individuals under the Waiver Programs follow the definitions in Section 3400 with the following exceptions:

I. Gross income of an individual must be less than or equal to the Categorical Nursing Care limit. (see Chart IVa). If income exceeds this amount, determine eligibility using Medically Needy process in Section 6000.

II. There is no deeming of income from the spouse.

III. If the income of the individual is being reduced due to previous overpayments by government agencies the reduced payment amount is used.

5070 RECIPIENT'S COST OF CARE

Cost of care is determined by the budgeting process for that Waiver and paid to the appropriate agency. The cost of care is due for each month for which services are provided even if services are not provided for a full calendar month.

Recipient's cost of care may be adjusted without timely notice and may also be adjusted retroactively. See Section 4530.

5080 BUDGETING

NOTE: To determine eligibility for the buy-in, see Sections 3200 and 3500. VA pensions that are Aid and Attendance or based on unusual medical expenses are not counted as income in determining eligibility or the cost of care in the Home Based Waivers.

I. Determine the individual's gross monthly income. If this figure is over the Categorical Nursing Care limit (see Chart IVa), use the SSI related budget for an individual (Section 3520) and the deductible process (Section 6000) to determine eligibility. Once the individual is Medicaid eligible, use the following steps to determine the individual's cost of care.

II. An adjustment may be made if there are current federal, state or local income tax deductions from the institutionalized spouse's gross income. Usually the amount of taxes withheld will be based on the previous year's income tax return. The adjustment for taxes cannot exceed the current tax liability. A deduction for past due taxes is not allowed. For example, last year $600 was due in income taxes. $80 per month is withheld for income tax. Only $50 per month can be allowed as a deduction.

NOTE: If an institutionalized spouse is paying estimated quarterly taxes, use these for an adjustment in the gross income. The procedure is the same as if the taxes were being withheld.

III. Subtract 125% Federal Poverty Level for 1 (see Chart VI). This is the Personal Needs Allowance for the individual. For the ALPHA Waiver, in addition, subtract the actual costs of the following disability-related expenses that are not payable by the Waiver, the Medicaid program, or a third party payor.

Home access modifications: ramps, tub/shower modifications and accessories, power door openers, shower seat/chair, grab bars, door widening.

Communication devices: adaptations to computers for communication or environmental control, speaker telephone, teletext devices.

Wheelchair (manual or power) accessories: accessories, lab tray, seats and back supports.

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Adaptations to transportation vehicles: adapted carrier and loading devices, one communication device for emergencies (limited to purchase and installation), adapted equipment for driving.

Hearing aids.

Glasses and adapted visual aids.

Environmental control units: devices that substitute for touch control such as a voice activated device to adjust lighting.

Assistive animals (purchase only).

Personal emergency response systems.

IV. Subtract the cost of:

A. Medicare payments for the individual.

B. Health insurance premiums incurred by the individual for the individual and/or the individual's spouse if the spouse is covered by Medicaid and is residing in a Cost Reimbursed Boarding Home or nursing facility or covered by a Home Based Waiver.

* Premiums must be incurred by the Medicaid recipient. If the health insurance is provided by the community spouse through his/her coverage, this is not considered to be a cost incurred by the Medicaid recipient. It is a cost incurred by the community spouse.

NOTE: Indemnity insurance premiums are not allowed. These are policies that pay for length of stay or a condition but not for a specific service. Third Party Liability should be contacted to assess cost effectiveness. If cost effective TPL will arrange for premium payment.

C. Certain Medical Expenses:

(1) Paid or unpaid medical expenses incurred by a Medicaid covered individual, while residing in a facility, for a necessary medical services as long as:

(a) the service is not covered in the per diem rate of the facility, (See Appendix 4-3).

(b) the service is not one the facility is expected to provide. The facility is expected to provide services contained in a written order or plan of care established by the individual's physician.

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(2) Unpaid medical expenses incurred by the individual for necessary medical services. This includes payment on the unpaid balance of a loan taken out to pay for medical expenses incurred prior to Medicaid coverage provided (a) the proceeds of the loan were used to pay the medical bill. Only the amount of the loan actually used to pay the medical bill may be deducted and (b) only the principal (and not the interest) part of the unpaid balance may be used as a deduction.

(3) A medical expense will not be deducted from the cost of care if:

(a) the expense was covered by insurance (including Medicare).

(b) the expense was not covered due to a Medicaid penalty period of ineligiblity.

(c) the Department has determined that the expense was not the responsibility of the individual because a medical assessment was not timely and requested by the facility or because the facility did not timely and adequately assist the individual with filing a Medicaid application. This determination is made by the Bureau of Elder and Adult Services.

(d) the expense is the unpaid cost of care to a medical institution or a Waiver agency during periods o Medicaid coverage.

(e) the expense was for a Medicaid covered service and the individual was covered by Medicaid.

(4) Verified medical expenses are deducted from the cost of care in the month following the month in which the bills are received in the regional office.

V. Subtract any spousal allocation. To determine this:

A. Determine the spouse's gross monthly income, including SSI and AFDC payments.

B. Subtract the gross monthly income from the maximum spousal allowance (see Chart IVb).

C. The balance is the spousal allocation.

VI. Subtract any dependent allocation. When an individual eligible under the Waivers has dependents living at home, an allocation may be allowed for their needs. For purposes of this section, a dependent is defined as a minor or dependent child, dependent parents, or dependent siblings of the waivered individual or non-waivered spouse. These dependents are individuals who may

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be claimed for tax purposes under Internal Revenue Code. To determine the allocation:

A. Determine the dependent(s) gross monthly income, including SSI and AFDC payments.

B. Subtract the gross monthly income from the appropriate maximum dependent allowance. (See Chart II.)

C. The balance is the dependent allocation.

VII. The remainder is the individual's cost of care.

EXAMPLE:

Don Renoir is 75 years old. He has applied for the Elderly Waiver. Assets in his name only are under $2,000. He receives Social Security and a pension totaling $1,219 per month.

His spouse, Claudette, has Social Security of $400 per month.

Their 40 year old son, who is their dependent, lives with them. He has zero monthly income.

$1,219.00	Mr. Renoir’s gross monthly income
-839.00	personal needs allowance for Mr. Renoir (125% of FPL)
$380.00	
-43.80	Medicare Part B premium
$336.20	
-104.00	spousal allocation
$232.20	
-154.00	dependent allowance
$78.20	Mr. Renoir’s cost of care

Spousal allocation is determined as follows:

$504.00	maximum spousal allocation
-400.00	spouse’s gross income
$104.00	spousal allocation

Dependent allocation is determined as follows:

$154.00	maximum dependent allowance
-0.00	income of Mr. Renoir’s son
$154.00	dependent allocation

5090 KATY BECKETT COVERAGE

Katy Beckett is not a Home and Community Based Waiver as are other groups listed in the 5000 section. This is an optional Medicaid coverage group for those who are ineligible for AFDC-related coverage or for coverage as an SSI-related child and who meet the criteria listed below.

I. age 18 and under;

II. residing in the community (not in a medical institution);

Ill. meet the medical need criteria established by Medicaid;

IV. meet the SSI criteria for disability;

If these criteria are met, the income and assets of the child only are considered. Parental income and assets are disregarded. There is no cost of care and there is no penalty for transfer of resources.

V. gross income as defined in SSI-related coverage must be less, than or equal to the Categorical Nursing Care limit (see Chart IVa). If income exceeds this amount the individual is not eligible;

VI. countable assets as defined in Sections 3300, 3330, and 3340 must be less than $2,000.

EXAMPLE:

Terry is 12 years old. She lives with her mother, father and her 15 year old brother. Her parents have assets totaling $958.28. Her father earns $2,942.98 monthly. Based on the family income, Terry would have a large deductible AFDC-related. Even if she was found disabled SSI-related, she would still have a large deductible. Based on her medical condition, a disability determination is made and classification requested based on the Katy Beckett waiver. Terry is found disabled and classified for the waiver. She is eligible based on zero income and assets.

If a child under age 18 is getting Medicaid coverage through the SSI cash program and he/she becomes ineligible for an SSI cash payment due to the parents' income or assets, the child may continue to get full Medicaid coverage and a $40 payment through the SSI and State Supplement program if the child:

- is disabled, and,
- received SSI benefits while in a medical facility (hospital or nursing home) for at least one month, and,
- meets the medical need standard for "Katy Beckett".

The SSI office will ask the state Department of Human Services to see if the child meets the medical need standard for the "Katy Beckett" option. The SSI office will let the parents know if the child meets the criteria and can get the $40 payment from SSI/State Supplement as well as continued Medicaid coverage. SSI may refer to this option as the "waiver of parental deeming".

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